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**In the Supreme Court of the United States**

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TOBY DOUGLAS, Director, California Department
of Health Care Services,
*Petitioner,*
v.
INDEPENDENT LIVING CENTER OF SOUTHERN
CALIFORNIA, INC., *et al.*,
*Respondents.*

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TOBY DOUGLAS, Director, California Department
of Health Care Services,
*Petitioner,*
v.
CALIFORNIA PHARMACISTS ASSOCIATION, INC., *et al.*,
*Respondents.*

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TOBY DOUGLAS, Director, California Department
of Health Care Services,
*Petitioner,*
v.
SANTA ROSA MEMORIAL HOSPITAL, *et al.*,
*Respondents.*

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*On Writs of Certiorari To The United States Court of Appeals For the Ninth Circuit*

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**Brief of *Amici Curiae* AARP, Families USA, et al.,**

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## INTEREST OF *AMICI CURIAE*[1]

*Amici* are organizations committed to serving the needs of low-income persons, including older Americans, individuals with disabilities, children, and women of child-bearing age. *Amici*'s work involves promoting public awareness of the disproportionate need for health care and barriers to care experienced by these populations and advocating for their interests and legal rights. It is in this last capacity that *amici* submit this Brief, asking the Court to affirm the decisions below.

**AARP** is a non-partisan, non-profit membership organization for people 50 and over. AARP advocates for health and economic security for everyone and in particular for vulnerable people of all ages, including low-income people and persons with disabilities. AARP supports access to and expansion of quality health care through publicly administered health insurance programs, including Medicaid, an essential safety net program that provides coverage to people who would otherwise be denied health care. To further that end, Medicaid recipients' access to the courts to challenge the denial of Medicaid services is critical. **Families USA** is the national, nonprofit and nonpartisan organization for health care consumers, dedicated to the achievement of high-quality, affordable health

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[1] No counsel for a party authored this brief in whole or in part or made a monetary contribution to fund the preparation or submission of this brief. No persons other than the *amici*, their members or their counsel made such a monetary contribution. The parties consented to the filing of this brief.

coverage and care for all Americans. For the past 29 years, Families USA has led various coalition efforts to protect and expand health coverage for low-income families, including the National Medicaid Coalition that it chairs.

The **National Legal Aid and Defenders Association** is the largest organization in the United States dedicated solely to securing equal justice for the disadvantaged in the civil and criminal justice systems. NLADA members represent thousands of families in need of adequate health care and access to the courts. The **National Health Law Program** is a 40-year-old public interest law firm that works to advance access to quality health care and protect the legal rights of low-income and underserved people. The **National Disability Rights Network** (NDRN) is the non-profit membership association of protection and advocacy (P&A) agencies that are located in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Territories. For 30 years, P&As have worked with children and adults with disabilities who depend on Medicaid-funded services and supports to enable them to live in the community rather than in institutions. Founded in 1986, the **Center for Medicare Advocacy** is a non-profit public interest law organization that represents older and disabled people throughout the United States. The Center works to advance fair access to Medicare, Medicaid and quality health care through individual representation, education, policy analysis, administrative advocacy, and litigation.

**First Focus** is a bipartisan advocacy organization that is committed to making children and families a priority in federal policy and budget decisions. In all of its work, First Focus strives to ensure that every child in America has access to the high quality, comprehensive, affordable health care they need to grow up to become healthy and productive adults. For over 25 years, **Voices for America's Children**, the nation's largest network of multi-issue child advocacy organizations, has directly advocated for full implementation of the Medicaid Act, in order to improve access to high-quality, age-appropriate health care for all children in need. The **Children's Dental Health Project** is a national non-profit organization with the mission of creating and advancing innovative solutions to achieve oral health for all children so that they reach their full potential. The **National Center for Youth Law** (NCYL) is a private, non-profit organization devoted to using the law to improve the lives of poor children nation-wide. For almost 40 years, NCYL has worked to protect the rights of low-income children and to ensure that they have the resources, support and opportunities they need to become self-sufficient adults. Amicus **National Housing Law Project** is a charitable nonprofit corporation established in 1968 whose mission is to use the law to advance housing justice for low-income people by increasing, preserving and improving the supply of decent, affordable housing; by expanding and enforcing tenants' and homeowners' rights; and by increasing housing opportunities for people protected by fair housing laws. The **National REACH Coalition** was

established in 2004 to challenge community and faith-based organizations, public health agencies and academic institutions working with and in marginalized communities to find effective strategies and community-based interventions to eliminate inequities in health.

The **Disability Rights Legal Center** (DRLC) is a non-profit legal organization that was founded in 1975 to represent and serve people with disabilities. The DRLC assists people with disabilities in attaining the benefits, protections and equal opportunities guaranteed to them under the Rehabilitation Act of 1973, the Americans with Disabilities Act, Individual with Disabilities Education Improvement Act, and other federal and state laws. The **American Network of Community Options and Resources** (ANCOR) is a nationwide nonprofit association representing and advocating for more than 800 private providers of community living and employment services and supports to more than 500,000 people with disabilities of all ages. For more than 40 years, ANCOR has represented the capacity and ability of private providers to ensure access by the individuals they support, the majority of whom depend upon Supplemental Security Income and Medicaid.

**Planned Parenthood Federation of America** (PPFA) is the nation's largest and most trusted voluntary reproductive health care organization. PPFA's 83 affiliates operate more than 800 healthcare centers nationwide. In addition to providing reproductive health care, PPFA and its

affiliates are among the nation's most active and widely recognized advocates for increased access to comprehensive reproductive health services and education. PPFA is committed to promoting and preserving full reproductive choice for all people and to providing access to high quality, confidential, reproductive health services. The **National Family Planning & Reproductive Health Association** (NFPRHA) represents the broad spectrum of family planning administrators and clinicians who serve the nation's low-income and uninsured. NFPRHA's more than 400 institutional members operate or fund a network of more than 3,700 health centers and service sites in 48 states and the District of Columbia, providing family planning and other preventive health services to millions of low-income and uninsured individuals each year.

The mission of **National Latina Institute for Reproductive Health** (NLIRH) is to ensure the fundamental human right to reproductive health and justice for Latinas, their families and their communities through public education, community mobilization and policy advocacy. NLIRH is the nation's only reproductive health policy and advocacy organization working on behalf of the reproductive health and justice of the nation's Latina women. The **Black Women's Health Imperative** (Imperative) is the only Black national organization dedicated to promoting optimum health for Black women across the life span—physically, mentally and spiritually. The **National Asian Pacific American Women's Forum** (NAPAWF) is the only national, multi-issue Asian and Pacific Islander

(API) women's organization in the country. NAPAWF's mission is to build a movement to advance social justice and human rights for API women and girls. The **Asian & Pacific Islander American Health Forum** (APIAHF) is a health advocacy non-profit organization dedicated to health justice through improving the health and well-being of more than 17 million Asian Americans, Native Hawaiians, and Pacific Islanders living in the United States and its jurisdictions. APIAHF believes that all persons have the right to be healthy, to live in a thriving community, and to quality, affordable, and accessible health care.

## SUMMARY OF ARGUMENT

The impact of California's across-the-board provider rate reductions on Medicaid beneficiaries' already insufficient access to health care is incompatible with and effectively nullifies the Equal Access Provision of the Social Security Act. If these rate reductions were to be implemented, even fewer providers in California would treat Medicaid patients, due largely to payment rates that are insufficient to cover the cost of providing the treatment. Delays in treatment and the inability to locate providers who will accept Medicaid payment are contributing to the poorer health of Medicaid beneficiaries' as compared to the general population.

The history and purpose of the Medicaid Act illustrate the need for and legality of private enforcement when states' violations of the Medicaid Act are harming program beneficiaries. The

Supreme Court has long recognized the right of program recipients and health care providers to enforce the Supremacy Clause and enjoin state laws that are inconsistent with the Medicaid Act or other provisions of the Social Security Act. The statutory scheme of the Medicaid Act does not preclude private enforcement. In other cases, the United States has repeatedly taken the position that private enforcement should complement federal agency remedies. Private enforcement is needed in these cases because the State's payment rates are too low to enlist sufficient numbers of Medicaid participating providers, thus creating barriers to care for Medicaid beneficiaries.

## ARGUMENT

### I. The History And Purpose Of Medicaid Show The Need For Private Enforcement.

Millions of Americans depend on their states' Medicaid programs operating as the Constitution and Congress intend. Over the history of the program, private enforcement has been the primary means of halting ongoing state violations of federal law and realizing Medicaid's promises and protections.

Title XIX of the Social Security Act established Medicaid in 1965. *See* 42 U.S.C. §§ 1396-1396w-5. Cooperatively funded by the federal and state governments, Medicaid is designed to provide low income program beneficiaries with

insurance that will allow them to obtain care and services from the private health care sector, including hospitals, doctors, pharmacies, and nursing homes. *See* Rand E. Rosenblatt et al., *Law and the American Health Care System* 415 (1997). Congress' "very clear ... intent [was] that the medical and remedial care and services made available to recipients under Title XIX be of high quality and in no way inferior to that enjoyed by the rest of the population." *Id.* at 416, *citing* U.S. Dep't of Health, Educ., and Welfare, *Handbook of Public Assistance Administration* § D-5140.

Before Medicaid was enacted, low income, uninsured people obtained health services through a patchwork of programs, such as hospital charity care and local programs for the poor. This system provided uneven coverage from state to state and within states. The Medicaid Act was intended to change this by providing for a uniform and statewide medical insurance program, while allowing for some variation among states. *See* Social Security Amendments of 1965, Pub. L. No. S9-97, 79 Stat. 266 (July 30, 1965).

Designed to address the more complex health needs of people with disabilities and the limited finances of low income people, Medicaid covers a range of necessary health and support services for people in need. Nearly 60 million people in the United States depend on Medicaid for their health care. Medicaid covers 30 million children (one in every three children in the United States) for medical, dental and developmental screening and

treatment. *See* Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Matters: Understanding Medicaid's Role in Our Health Care System* 1 (Mar. 2011) [hereinafter *Medicaid Matters*], http://www.kff.org/medicaid/upload/8165.pdf; Kaiser Comm'n on Medicaid & the Uninsured, *Top 5 Things to Know about Medicaid* 2 (2011) [hereinafter *Top 5 Things*], http://www.kff.org/medicaid/upload/8162.pdf. Nearly 15 percent of women between the ages of 15 and 44 rely upon Medicaid for services, including breast and cervical cancer screening and treatment, testing and treatment for sexually transmitted diseases, and pregnancy-related care. *See* Guttmacher Inst., *Women of Reproductive Age Hit Hard by Recession, New Census Data Show* (2010), http://www.guttmacher.org/media/inthenews/2010/09/17/index.html. Over 14 million older persons and people with disabilities depend on Medicaid. Twenty percent of all non-elderly people with disabilities in the United States depend on Medicaid to treat a range of conditions, including "physical impairments, blindness, limitations from spinal cord injury, severe mental and emotional conditions, and other disabling conditions, such as cerebral palsy, cystic fibrosis, Downs Syndrome, mental retardation, muscular dystrophy, autism, spina bifida, and HIV/AIDS." Andy Schneider et al., The Kaiser Comm'n on Medicaid and the Uninsured, *The Medicaid Resource Book* 18 (July 2002). Medicaid is the largest single purchaser of long-term care services for the elderly and non-elderly people with disabilities in the United States. For example, seven of every ten nursing home residents are covered by Medicaid, and Medicaid pays for 43

percent of the total long term care expenditures in the United States. *Medicaid Matters*, *supra*, at 2-3.

Over its forty-six year history, Medicaid has played a pivotal role in arranging for and funding health services. The program has resulted in numerous successes. It has reduced the numbers of uninsured, helped provide near-universal protection against communicable childhood diseases, played a major role in reducing infant mortality rates, and provided a critical life line to individuals with chronic and disabling conditions. *See* Schneider et al., *supra*, at 2; *Medicaid Matters*, *supra*, at 1-2. Medicaid is a cornerstone of the nation's health care system.

Medicaid is an entitlement program. Accordingly, "all individuals" who meet the eligibility requirements are entitled to receive a federally established set of benefits with "reasonable promptness." *See* 42 U.S.C. § 1396a(a)(10)(A), 42 U.S.C. § 1396a(a)(8). *See Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981) ("An individual is entitled to Medicaid if he fulfills the criteria established by the State in which he lives."). The federal and participating state governments have a legal obligation to pay for and administer medical assistance needed by program beneficiaries in compliance with the requirements of the Medicaid Act and implementing regulations. *Id.* Thus, Medicaid coverage responds as emerging populations and economic needs arise, including rising unemployment, loss of private health care coverage, disasters, increasing disability rates, and an aging

society. *See Medicaid Matters, supra*, at 1-2; Schneider et al., *supra*, at 2.

Entitlement to Medicaid triggers legal rights, including the right to enforce certain statutory requirements that are placed on the states. It is this entitlement that makes Medicaid insurance and that assures individuals that coverage will be there when care is needed. Since the beginning of the Medicaid program, beneficiaries have been able to make their entitlement real by bringing *Ex parte Young* actions for prospective injunctive relief against state officials who are engaged in ongoing violations of federal law. Since the beginning of the Medicaid program, these cases have been based not only on 42 U.S.C. § 1983 but also on the Supremacy Clause. It is the Supremacy Clause that is at issue in this case.[2]

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[2] Section 1983 is not at issue here. *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), clarified that private enforcement under § 1983 is limited to federal statutory provisions that reflect unambiguous congressional intent to benefit the individual plaintiffs. The enforcement test is well-established. Thirty-two Medicaid cases have been decided in the circuit courts of appeals since *Gonzaga*, with no splits among the circuits. *See* National Health Law Program, *Update on Private Enforcement of the Medicaid Act Pursuant to 42 U.S.C. § 1983* (June 2011), http://www.healthlaw.org. Unlike other appellate courts, *Pediatric Specialty Care v. Ark. Dep't of Human Servs.*, 443 F.3d 1015 (8th Cir. 2006), allowed enforcement of 42 U.S.C. § 1396a(a)(30)(A). However, that decision was vacated by *Selig v. Pediatric Specialty Care*, 551 U.S. 142 (2007).

## II. California's Across-The-Board Medicaid Rate Cuts Are Incompatible With And Effectively Nullify The Equal Access Provision Of The Social Security Act.

When providers leave Medicaid programs due to inadequate payment rates, Medicaid patients experience problems locating alternative, appropriate care and are harmed. The U.S. Department of Health and Human Services recently proposed regulations that recognize that states' long running, budget-driven failures to comply with 42 U.S.C. § 1396a(a)(30)(A) are causing Medicaid recipients to be denied sufficient access to covered care and services. *See* 76 Fed. Reg. 26342, 26343 (May 6, 2011). And, several courts, looking at the issue both before and after *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), have noted this national problem. *See, e.g.*, *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 701 n.5 (5th Cir. 2007) (denying Medicaid recipients relief under § 1983 after discussing six such cases); *see also id.* (taking judicial notice of the Texas' Medicaid agency's statement that "[r]ate increases for physicians would promote access to care for Medicaid clients that would likely erode without the increase").[3]

Even before California enacted the cutbacks, its Medicaid provider payments were the forty-

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[3] *See, e.g.*, David L. Skaggs et al., *Access to Orthopedic Care for Children With Medicaid Versus Private Insurance: Results of a National Survey*, 26 J. Ped. Orthopaedics 400 (2006).

seventh *lowest* in the nation.[4] Access to office-based physicians in California is so limited that some recipients languish months before getting an appointment for treatment.[5] Patients of facilities with average wait times of 31 days or longer face significantly higher odds of dying than patients who were treated at medical facilities with shorter wait times.[6]

Participation in Medi-Cal among medical and surgical specialists is even lower than participation by primary care physicians because few doctors are willing to treat Medi-Cal patients because reimbursement rates are insufficient to cover the

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[4] Stephen Zuckerman, Amy Williams & Karen Stockley, Cal. HealthCare Found., *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare* 23 (Apr. 2009), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFeeComparison.pdf.

[5] *See* Evan Halper, *Further Fee Cuts Force a Medi-Cal Exodus: Doctors are Rejecting New Patients*, L.A. Times, Mar. 24, 2008, 2008 WLNR 5628983; Duane W. Gang, *Riverside County Threatens to Pull Out of Medi-Cal Mental Health Program*, The Press Enterprise (Riverside, Cal.), Apr. 1, 2008, http://www.pe.com/localnews/healthcare/stories/PE_News_Local_H_board02.430192d.html.

[6] *E.g.* Julia C. Prentice & Steven D. Pizer, *Delayed Access to Health Care and Mortality*, 42 Health Services Res. 644-62 (2007); *cf.* Joanna Bisgaier & Karin V. Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance*, 364 N. Eng. J. Med. 2324 (Jun. 16, 2011) (finding Medicaid recipients in Illinois wait 22 days longer than the privately insured for an appointment).

costs of treatment.[7] Pediatric surgeons, gynecologists and obstetricians, otolaryngologists, mental health professionals, and dentists have all reported that the actual cost of providing care is well above what Medi-Cal reimburses for their service.[8] Medi-Cal reimbursement rates have not significantly increased since 2001; in fact, California's rates increased only two percent from 2003 to 2008, over seven times less than the national average and ten times less than the rate of inflation over the same period.[9]

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[7] *See, e.g.*, Edward C. Wang et al., *Inequality of Access to Surgical Specialty Health Care: Why Children With Government-Funded Insurance Have Less Access Than Those with Private Insurance in Southern California*, 114 Pediatrics 584 (2004) (concluding 97 out of 100 surveyed otolaryngologists would offer an appointment to a privately insured child as compared to 27 for a child on Medi-Cal, with low monetary reimbursement given as chief reason for refusal).

[8] *See* David L. Skaggs et al., *Access to Orthopedic Care for Children with Medicaid Versus Private Insurance in California*, 107 Pediatrics 1405, 1406 (2001) (finding that cost of treatment by pediatric orthopedic surgeon exceeded Medi-Cal reimbursement); *Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1116 n.5 (E.D. Cal. 2003) (finding Medi-Cal reimbursement rates for OB/GYN services set below provider costs), *rev'd on other grounds* 140 Fed. App'x 677 (9th Cir. 2005); Halper, *supra* note 5 (reporting Medi-Cal reimbursement for tonsillectomies is insufficient to cover surgical costs); Wang, *supra* note 8 (finding Medi-Cal funds for mental health treatment do not cover costs); Martin Espinoza, *Dental Care Called a Health Care Crisis*, Press Democrat (Santa Rosa, Cal.), June 16, 2011, http://www.pressdemocrat.com/article/20110616/ARTICLES/110619585?p=all&tc=pgall (noting low dental participation because "it costs more to bill for Denti-Cal than what you get").

[9] Zuckerman, Williams & Stockley, *supra* note 4, at 11.

Since Medicaid recipients are in significantly poorer health than the general population, the consequences they face from reduced access to care leave them in a dire situation.[10] Lack of access to preventive care or treatment is the third leading cause of death for adults age 55-64, behind heart disease and cancer and the sixth-leading cause of death among adults ages 25 to 64, ahead of HIV/AIDS and diabetes.[11] Low Medi-Cal provider participation results in significantly worse and even grave health outcomes for recipients.

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[10] *See* Jack Hadley, Kaiser Comm'n on Medicaid and the Uninsured, *Sicker and Poorer: The Consequences of Being Uninsured* 46 (2002), http://www.kff.org/uninsured/upload/Full-Report.pdf.

[11] *See* Stan Dorn, Urban Inst., *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality* 4 (2008), http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf; Karen Davis, Testimony before U.S. Senate, Special Comm. on Aging, The Commonwealth Fund, Time for Change: The Hidden Cost of a Fragmented Health Insurance System 2 (2003), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221616.

## III. The Supreme Court Has Consistently Recognized That Program Beneficiaries Can Enjoin State Laws That Are Invalid Under The Supremacy Clause, And Congress Has Recognized This Right.

On numerous occasions dating from the early 1970s, the Supreme Court has held that beneficiaries of Social Security Act programs can bring preemption actions to enjoin state laws that conflict with federal law and are, thus, "invalid under the Supremacy Clause." *Townsend v. Swank*, 404 U.S. 282, 285 (1971). In *Bennett v. Arkansas*, 485 U.S. 395, 397 (1988) (per curium), the Court held that a state statute that conflicted with the Social Security Act was preempted by operation of the Supremacy Clause. The Court noted that the Social Security Act "unambiguously rules out any attempt to attach Social Security benefits," while the Arkansas statute at issue in the case "just as unambiguously allows the State to attach those benefits." *Id.* at 397. The Court held that "this amounts to a 'conflict' under the Supremacy Clause—a conflict the State cannot win." *Id. See Blum v. Bacon*, 457 U.S. 132, 138 (1982) (holding state welfare regulations that conflicted with regulations promulgated pursuant to the Social Security Act "are invalid under the Supremacy Clause"); *N.Y. State Dep't of Social Servs. v. Dublino*, 413 U.S. 405, 423 n.29 (1973) (applying preemption analysis but finding no inconsistency, noting that "[c]onflicts [in Social Security Act programs], to merit judicial rather than cooperative federal-state resolution, should be of substance and not merely

trivial or insubstantial. But if there is a conflict of substance as to eligibility provisions, the federal law of course must control."); *Carleson v. Remillard*, 406 U.S. 598, 604 (1972) (holding that a California regulation excluding a parent's absence because of military service from the definition of "continued absence" from home conflicted with Social Security Act AFDC eligibility provisions and was invalid under the Supremacy Clause); *see also Ark. Dept. of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006) (assuming preemption cause of action without discussion). *See also PhRMA v. Walsh*, 538 U.S. 644 (2003) (plurality opinion) (deciding merits of preemption claim brought by provider organization); *Dalton v. Little Rock Family Planning Services*, 516 U.S. 474, 478 (1996) (applying Supremacy Clause in provider case and remanding for entry of injunction to extent state constitution conflicted with Medicaid Act). [12]

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[12] The petitioner and his *amici* voice concern that a litigation floodgate will be produced if plaintiffs are able to enjoin state laws that are invalid under the Supremacy Clause. However, in a line of cases dating back more than 30 years, each of the circuit courts of appeals already used Supremacy Clause analysis to determine the validity of state Medicaid laws without dire consequences coming to pass. *See, e.g., PhRMA v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001) (considering whether state statute conflicted with Medicaid so as to be invalid under Supremacy Clause); *Concourse Rehab. & Nursing Ctr., Inc. v. Whalen*, 249 F.3d 136, 146 (2d Cir. 2001); *Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F.3d 170, 178 (3d Cir. 1995 ("The Supremacy Clause requires invalidation of any state constitutional or statutory provision that conflicts with federal law ... and compels compliance by participants in Title XIX federal aid programs with federal law and regulations."); *Randall v. Lukhard*, 729 F.2d 966 (4th Cir. 1984) (en banc)

In 1994, Congress twice amended the Social Security Act to make clear that private causes of action are available. *See* 42 U.S.C. §§ 1320a-2, 1320a-10. Those amendments overruled parts of *Suter v. Artist M.*, 503 U.S. 347 (1992). They also affirmed the clear understanding of Congress that program beneficiaries would maintain access to the courts on the grounds that were recognized by this

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(adopting holding from *Randall v. Lukhard*, 709 F.2d 257, that a Virginia rule was invalid because it conflicted with a provision of the Medicaid Act); *Planned Parenthood of Hous. & Se. Tex. v. Sanchez*, 403 F.3d 324, 331 (5th Cir. 2005) ("[I]t is well-established that the federal courts have jurisdiction under 28 U.S.C. § 1331 over a preemption claim seeking injunctive and declaratory relief."); *Planned Parenthood Affiliates of Mich. v. Engler*, 73 F.3d 634, 637 (6th Cir. 1996) (because Michigan law "conflicts with the program requirements of Medicaid, it must be held invalid under the Supremacy Clause"); *Zbaraz v. Quern*, 596 F.2d 196, 202 (7th Cir. 1979) (remanding with instructions to enjoin enforcement of state law to extent it conflicted with Medicaid); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006) (granting recipients' request to enjoin Medicaid service cutback, holding "preemption claims are analyzed under a different test than section 1983 claims, affording plaintiffs an alternative theory for relief when state law conflicts with a federal statute or regulation."); *Lewis v. Hegstrom*, 767 F.2d 1371, 1375 (9th Cir. 1985) (applying "settled proposition that state regulations which are inconsistent with federal [Medicaid] law are invalid under the Supremacy Clause"); *Hern v. Beye*, 57 F.3d 906, 906 (10th Cir. 1995) (affirming injunction prohibiting enforcement of state law "to the extent it conflicts with federal Medicaid law"); *Planned Parenthood Fed'n v. Heckler*, 712 F.2d 650, 663-64 (D.C. Cir. 1983) ("It is elementary that under the Supremacy Clause of the Constitution states are not permitted to establish eligibility standards for federal assistance programs that conflict with the existing federal statutory or regulatory scheme.").

Court prior to 1992, the year *Suter* was decided. *See* H.R. Conf. Rep. No. 761, 103d Cong., 2d Sess., at 926 (1994), *reprinted in* 1994 U.S.C.C.A.N. 2901, 3257 ("The intent of this provision is to assure that individuals who have been injured by a State's failure to comply with the Federal mandate of the State plan titles of the Social Security Act are able to seek redress in the federal courts to the extent that they were able to prior to the decision in *Suter v. Artist M.*"). Sections 1320a-2 and 1320a-10 clearly mean that Congress intends preemption actions under the Supremacy Clause to live on as a means of preventing state officials from acting contrary to the requirements of the Social Security Act.

## IV. The Medicaid Act's Statutory Scheme Is Not Inconsistent With The Need For Private Enforcement Of The Supremacy Clause To Prevent State Medicaid Officials From Acting Contrary To Federal Law.

In its brief supporting the petitioner, the United States argues that allowing Medicaid recipients and providers access to the courts is inconsistent with Medicaid's "statutory scheme" vesting enforcement authority in the Department of Health and Humans Services (DHHS). Brief for the United States as *Amicus Curiae* Supporting Petitioner at *10, *Douglas v. Indep. Living Ctr. of S. Cal. et al.* (May 2011) (Nos. 09-958, 09-1158, and 10-283) [hereinafter U.S. Indep. Living Ctr. Brief 2011]. This argument is inconsistent with Supreme Court precedent and the expressed opinion of Congress,

ignores DHHS's limited enforcement authority, and contradicts the position the United States has taken in other cases.

A statutory enforcement scheme either substitutes for private enforcement or it does not. In *Wilder*, this Court has held that the Medicaid Act does not contain a statutory scheme that would replace private enforcement. *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 521-22 (1990); *see generally City of Rancho Palo Verdes v. Abrams*, 544 U.S. 113, 121-22 (2005) (listing Medicaid as a statute whose private judicial enforcement is not foreclosed based on a statutory enforcement scheme). When Congress amended the Social Security Act in 1994, it expressed its intent that private enforcement of the Social Security Act be determined according to the grounds applied in this Court's decisions prior to 1992. *See* 42 U.S.C. §§ 1320a-2, 1320a-10. Thus, the grounds established in *Wilder*, decided in 1990, are included in those grounds Congress approved in its 1994 amendments to the Social Security Act.

To be sure, Medicaid's statutory scheme does include a provision authorizing the Secretary of DHHS to enforce federal Medicaid law: 42 U.S.C. § 1396c authorizes the Secretary to terminate federal funding to states whose plans are not in compliance with the Act. Termination of federal funding is a draconian remedy, one that DHHS rarely uses. As noted by the United States when it opposed certiorari in these cases, "[P]rograms in which the drastic measure of withholding all or a major portion of federal funding if the only available remedy would

be generally less effective than a system that also permits awards of injunctive relief in private actions." Brief for the United States as *Amicus Curiae* at *19, *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal.*, 572 F.3d 644 (9th Cir. 2009) on petition for cert December 2010 [hereinafter U.S. Indep. Living Ctr. Brief Dec. 2010].[13] *See also Va. Office for Prot. & Advocacy v. Stewart*, 131 S.Ct. 1632, 1639 n. 3 (2011) ("The fact that the Federal Government can exercise oversight of a federal spending program and even withhold or withdraw funds—which are the chief statutory features respondents point to—does not demonstrate that Congress has displayed an intent not to provide the more complete and more immediate relief that would otherwise be available under *Ex parte Young*." (citation omitted)).

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[13] The United States cites a regulation recently proposed by DHHS as evidence that DHHS is "committed to ensuring that" Medicaid beneficiaries have meaningful access to covered services. U.S. Indep. Living Ctr. Brief 2011 at *11-12 (citing Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342 (May 6, 2011). Regardless of DHHS's alleged commitment, the proposed regulations do not contain an enforcement scheme that would render the need for private enforcement unnecessary. And while issuance of final regulations will hopefully provide guidance that states will follow, thereby decreasing their noncompliance with the statutory requirement of rates sufficient to assure equal access, these proposed regulations do not remove the necessity of private enforcement in situations where recalcitrant states continue to ignore the statutory mandate.

Despite the position taken here, the United States elsewhere recognizes that private enforcement complements the Secretary's oversight. For example, the United States is supporting private enforcement in a pending Medicaid case. In May 2011, Indiana enacted a statute that bars certain entities that perform abortions from participating in Medicaid. Medicaid-participating providers who were barred from providing services and Medicaid recipients who lost access to care filed suit in federal court arguing that the state law is preempted by a specific Medicaid Act provision and that they have a federal right to enforce that provision pursuant to 42 U.S.C. § 1983. The United States filed an amicus brief urging the court to enjoin implementation of the Indiana law. *See Statement of Interest of the United States at *21-22, Planned Parenthood of Indiana, Inc.* v. *Commissioner of the Ind. State Dept. of Health*, June 16, 2011 (S.D. Ind. No. 1:11-cv-00630-TWP-DKL) [hereinafter U.S. Planned Parenthood Brief]. According to the United States, the recipients' and providers' request for injunctive relief was "particularly necessary" because "Indiana has expressed its view that operating a 'non-compliant program' is a 'lawful option for the State under the [Medicaid] statute,' so long as the State is willing to 'risk that the Secretary will turn off the funding spigot." *Id.* at *21-22; *see also, e.g.*, Statement of Interest of the United States of America, *John B. v. Emkes*, Feb. 18, 2011 (M.D. Tenn. No. 3-98-0168) (asking court to deny Tennessee's request to terminate a consent decree because the Medicaid child health screening and treatment provisions are privately enforceable by

Medicaid recipients); Brief for the United States as Amicus Curiae Supporting Respondents at *30, *Blessing v. Freestone*, 520 U.S. 329 (1997) (No. 95-1441) (arguing that private enforcement is "an important complement to the Secretary's necessarily macroscopic oversight of the State, by assuring that States carry out the specific duties" of the Social Security Act and arguing that federal-state cooperative program of the Social Security Act does not contain statutory scheme that precludes private enforcement); U.S. Indep. Living Ctr. Brief Dec. 2010 at *19 (arguing against certiorari in these cases, pointing out that application of a contract analogy "overlooks the important role private parties can and often do play in vindicating federal law. A system that relies solely on agency review may be less effective than a system of agency review supplemented by private enforcement"). *Cf. Chisholm v. Hood*, 110 F. Supp. 2d 499 (E.D. La. 2000) (ordering State to cover physical and related therapy services for Medicaid eligible children six years after CMS had informed the State that the Act required coverage of these services).

Nor do the private parties have another adequate remedy, despite some suggestions to the contrary. *See PhRMA*, 538 U.S. at 675 (Scalia, J., concurring). In *PhRMA*, Justice Scalia suggested that the plaintiffs only remedy for a violation of the Medicaid Act is to ask the Secretary of DHHS to terminate federal funding and thereafter file an Administrative Procedural Act action if they are dissatisfied with the outcome. *Id.* at 675 (citing 5 U.S.C. § 706(2)(A)). There is no such statutory

scheme, *see* 42 U.S.C. § 1316 (citing § 1396c), nor is there such an administrative scheme for Medicaid recipients or providers. The federal Medicaid regulations allow a State to obtain administrative and judicial review when it is dissatisfied with the denial of a state plan amendment or federal withhold of funding. *See* 42 C.F.R. §§ 430.30-430.104. Only CMS and the State are automatic parties to the administrative hearing, *id.* at § 430.76, and only the State has a right to judicial review, *id.* at § 430.38. The regulations permit individuals to petition the federal agency for permission to participate in the hearing, but participation is within the discretion of the presiding officer at the hearing. *Id.* § 430.76. The ability of a recipient or provider to seek permission to participate in a State's hearing before the Department is not a statutory scheme that displaces private enforcement. *See Rosado v. Wyman*, 397 U.S. 397, 406 (1970) (refusing to attach significance to the fact that HEW (predecessor to DHHS) was engaged in a study of the issues before the court or to impose an "exhaustion of administrative remedies" requirement, noting that under the regulations recipients could not "have obtained an administrative ruling since HEW has no procedures whereby welfare recipients may trigger and participate in the Department's review of state welfare programs."); *Almenzares v. Wyman*, 453 F.2d 1075, 1087 (2d Cir. 1971) (finding administrative petition scheme inadequate because of the "inability of welfare recipients to trigger such a proceeding, along with the natural reluctance of HEW to embark on a course that could lead to withdrawal of federal aid"); *Ariz. Dep't of Pub. Welf. v. Dep't of Health,*

*Educ. & Welf.*, 449 F.2d 456. 464, n.9 (9th Cir. 1971) (finding courts without jurisdiction to hear petitions from welfare recipients because § 1361 limits review to petitions from states and suggesting recipients bring direct declaratory action in district court finding such a remedy "preferable to a judgment ordering the cessation of the flow of federal [welfare] funds"). *See also Wilder*, 496 U.S. at 514 n.12 (acknowledging position of United States that there is no remedy under the APA because the decision to accept a states' assurance is entrusted to agency discretion); *id.* at 521-22 (rejecting argument that an action against the Secretary under the APA forecloses private enforcement).

## CONCLUSION

For the foregoing reasons, *Amici Curiae* respectfully request this Court to affirm the judgment of the Circuit Court.

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